

# MENTAL HEALTH



## AND PREVENTION FOR FAMILIES

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**There are many opportunities for improving mental health in family settings. Programs supporting couples to build better relationships, specific parenting interventions through the period of childbirth and child rearing, and early childhood interventions have all been shown to have significant benefits.**

**T**here has been a progressive development of prevention initiatives in the field of mental health in recent years (Raphael 1992; Mrazek and Haggerty 1994) that have built on more general earlier views (Caplan 1964) and recent mental health research.

While the specific causes of many psychiatric disorders are not established, there is now general agreement that a range of life circumstances and personal, social and biological factors contribute to vulnerability to disorder or precipitation of episodes of illness. In this context the family is central. Ample evidence exists of the negative processes that may increase risk, the protective processes that may promote resilience, and of the supportive and non-supportive responses that may also influence mental health outcomes.

Prevention frameworks include: primary – the lessening of incidence of disorder (preventing its onset); secondary – lessening prevalence through early effective treatment promoting recovery; and tertiary – effective rehabilitation to lessen disability. These are on a continuum with treatment, rehabilitation and maintenance of health. In examining prevention programs there needs to be a recognition of the importance of short-term, intermediate, and longer-term outcomes. In addition, care should be taken to evaluate prevention programs for adverse as well as positive side effects.

A multitude of prevention initiatives may target the family, from family formation, child bearing and child rearing stages, through family loss and breakdown, to the family issues of adult generations in the later period of life. These need to be included in a life span development framework. However, all these must be understood and interpreted in terms of the different meaning and nature of family life in different cultures, and the significance such broader issues will have for the mental health and wellbeing of family members. Key amongst these is the place of women, the nature of role delinquency, and the significance of children.

Although the structure of families may vary considerably across cultures and with societal changes (for example, the evolving

acknowledgement of the parenting capacity of gay families), core emotional attachments linking family, kith and kin and community are apparent universally. Babies who are not enveloped in such a network fail to thrive. If they survive, their physical, emotional and intellectual development is jeopardised.

### Formation of Couple Relationships

There has been much concern about the high rate of divorce in Western society and a belief, not well tested by research, that marital preparation may lessen the risk of marriage breakdown. Halford (1995) reviews the interventions helpful to marital functioning (and thus to the prevention of psychiatric disorder related to marital dysfunction). He notes that long-term pairing of adults occurs in most cultures, and is often based on social and economic considerations, rather than romantic love ideals of Western marriage. Expectations of life-long partnership, intimacy and the centrality of this relationship provide a framework on which the developments of the relationship, family life and circumstances are superimposed. Also inherent in understanding couples and families is the recognition of these adult attachments, and the significance of the affectional bonds that they involve.

Couple relationships may be a source of wellbeing and sustenance for the individual partners, or, alternatively, a source of distress. Marital problems are associated with an increased risk of depression for women and substance abuse for men, and these problems will also impact on children of the marriage. It is well recognised that the relationships found in studies of this kind are likely to be two-way. Violence in marriage is one manifestation of distress that is likely to have a significant negative impact on mental health of both partners and children. On the other hand, being in a satisfying marriage is associated with decreased risk of disorder. Marital interactions may be positive and rewarding, or they may be negative, escalating the difficulties of the couple or exacerbating the disorder of the individual.

Halford (1995) summarises the key findings about predictors of marital distress and

concludes that poor conflict management was the strongest, replicated predictor of marital distress and poor outcome. Analysis of Behavioural Premarital Intervention, one of the more systematic forms of premarital program, showed that this type of program could enhance communication skills and relationship satisfaction. A five-year follow-up study found lower rates of physical aggression, lower rates of divorce, and better communication and satisfaction (Markman et al. 1993). Similarly, Behavioural Marital Therapy, which has been shown to have significant effects, may also be used to enhance the couple relationship by promoting intimacy and positivity, communication skills and problem solving, and cognitive restructuring.

Thus, when effective, this form of couples therapy may lessen marital discord and prevent negative outcomes. These interventions may be helpful also in times of particular stress for the couple – for example, the birth of the first child, or the onset of severe life-threatening or chronic illness, including psychiatric disorder. Early intervention in the latter settings may be helpful in preventing problems for the partner of the sick person and contribute to improving the patient's outcome.

An important aspect of prevention may also be specific therapy to lessen the marital discord that leaves children vulnerable to disorder. Dadds et al. (1987) have shown that brief marital intervention may enhance the marriage of parents of children with conduct disorder and the long-term outcome for the child. Such intervention may enhance outcomes of depression in the parent where marital discord is a contributing factor to the depression, and similarly for substance abuse.

In view of the extensive evidence – such as that of Rutter (1989) identifying the role of marital discord as a contributing factor to disorder in the child – marital intervention may be valuable in preventing disorder in the child. These outcomes need to be established specifically, in short- and in long-term programs for preventive mental health interventions relevant to child disorder, and the value of such marital programs needs to be confirmed.

## Childbirth and Childrearing

There is substantial psychiatric vulnerability associated with giving birth and raising children – two central facets of family life. This may range from the risks of Post Natal Depression, affecting up to 10–15 per cent of mothers, through to parenting failures leading to abuse, neglect and even infant death. Barnett (1995) has reviewed the opportunities for prevention that may be available in relation to pregnancy and early parenting. She acknowledges it is not inevitable for the problems of the parents to be transmitted to the next generation, but that, having a dysfunctional family background and unhappy childhood may increase vulnerability, particularly in the face of stress.

Parents may have idealised expectations for their unborn child, and the birth of a baby at risk (low birth weight, handicapped, or sickly) may require significant adaptation. When the loss of a baby occurs through still-birth, neonatal death or sudden infant death, there is evidence that there is an increased risk of psychiatric disorder in the parents, particularly the mother, and that this is more pronounced with sudden infant death. Preventive intervention targeted to high-risk populations in such settings has been demonstrated to have significant preventive benefit, reducing the risk of negative outcomes. This may also prove helpful for other children in the family. Evaluation has shown this model can be adapted to educational and outreach programs, thus providing a broadly based effective preventive intervention that can be used with populations at risk (Murray 1996).

Genetic factors in both parent and child play a role in parenting, particularly in the provision of warmth (Kendler 1996). The complex mix of genetic influence on temperament and behaviour, as well as social learning, reflect on genetic–environmental interactions that may take negative or positive pathways. Clearly, however, despite the significant genetic contribution to parenting, this mix is not immutable, and social and psychological interventions may bring significant shaping processes to bear.

There has been inadequate research attention to the opportunities for preventive intervention for those at high psychosocial risk antenatally and through the pre-natal and early post-partum period. In view of the significant levels of abuse that many pregnant women experience, the lack of support and fearful expectations, the opportunities through antenatal preparation leading to improved mental health outcomes should be more systematically examined. It has been suggested that interventions may have a buffering effect in the event of adversity. Barnett (1995) concludes that there is evidence from a range of programs and studies that education, support and good systems of care, with informed consent for interventions, are likely to be helpful. Two have shown that two educational interventions brought enhanced health outcomes to parents and that their infants subsequently had fewer behavioural difficulties.

Antenatal psychosocial screening, education and care, plus the provision of support and, where necessary, specific psychological

support for the perinatal period, appear to be the crucial elements, the more so for women (and probably their partners) who are already psychologically vulnerable and at risk. It is likely that these supportive programs are particularly important where there is intervention or complication, such as Cesarean section. They are also critical where the mother has an established psychiatric illness – for instance, bipolar disorder.

Post Partum Depression has had greater recognition in recent times, and the development of screening measures such as the Edinburgh Post Natal Depression Scale has been helpful in enhancing detection to allow early intervention and management. This measure, used in the early post-partum period may also predict subsequent depression, as well as being used for detection. Counselling has been demonstrated to be effective in controlled trials (Holden et al. 1989) and thus has significant preventive implications for the infant in view of the behavioural and developmental problems that are more likely for the infants of mothers with Post Natal Depression, particularly when the mother's depression is severe or prolonged. Social support is also an effective component of intervention, whether through specific group programs or through self-help and support associations such as PANDA (Post and Antenatal Depression Association).

The parenting vulnerabilities associated with maternal depression may be part of a spectrum of vulnerabilities. Anxious mothers may also bring additional risk to their children, and intervention with highly anxious mothers has been shown to enhance mothers' competence and confidence, although no demonstrated benefit on mother–infant attachment has been shown.

**Family disruption, loss and illness, the impact of poverty and disadvantage, as well as violence, may all impact negatively on the mental health of family members. A positive, preventive approach based on current understandings can support the vital role of family in meeting affectional, role and nurturing needs of all family members, thus enhancing their wellbeing.**

Some more global programs have attempted to provide a preventive intervention and support for mothers/parents at high risk. These programs provide education, support and specific interventions, particularly home visitor programs over the early months and years. These programs aim not only to support parenting, but also to prevent child abuse and neglect. Home visiting and a family support program may be necessary, for example that of Olds et al. (1986a,b). This model emphasises parenting, promotes strengths and responsiveness (for example, to the infant's crying), and has been used with mothers at high risk, over a two-year period, and has demonstrated significant benefits. More broadly based community programs in the United Kingdom have also been reviewed by Barnett (1995) – for instance, New PIN

(New Parent Infant Network), and Homestart. These programs, she suggests, 'try to provide a substitute family which provide a very different model from the client's family of origin' (p. 113).

Key elements of these and other similar programs include the following: comprehensiveness; home visiting; beginning during pregnancy and continuing for several years post-partum. Outcomes include healthier infants, fewer low birth weight infants, fewer feeding difficulties, fewer accidents, less child abuse, improved marital relationships and parental competence and confidence, improved parent–infant relationships, and, in the longer term, improved social confidence for children, better education for mothers, and higher rates of family employment (Rae Grant 1991).

Many of these programs focus on young and disadvantaged parents and there are important preventive implications in terms of adolescent pregnancy and parenting. This may involve programs to prevent early parenthood and adolescent pregnancy, and when this does occur, to provide contraception and relationships education, counselling support, and early pregnancy programs to support young mothers and their infants.

### Early Childhood Programs

There is now a plethora of preventive programs for early intervention in preschool and early childhood years. These inevitably involve family frameworks. They are usually multi-component, particularly when the child enters the school years, so that the child, parents and school environment are all taken into account. While many are directed towards enhancing parenting skills, education, problem solving and social competence, development linked to educational frameworks are the common elements of programs directed to children themselves.

A unique program aimed at positive parenting for preschoolers (Triple P) is a multi-level family intervention which focuses on children who have behavioural problems and who are likely to be at risk of subsequent conduct problems. The program tailors the generic intervention elements to assessed requirements of parents and children, enhances parental competence and self-sufficiency, and promotes social competence in children. The program has shown significant benefits in controlled trials and has been generalised and extended for use, including to remote and rural settings (Sanders 1995).

The focus of a wide range of school based programs, that come into play in subsequent years, is on social problem solving, enhanced social skills and social competence for children, and more recently dealing with negative cognitions (for instance, with the aim of preventing depressive disorders).

Seligman et al. (1995) have adapted a schools based program to a program in which parents are taught to coach their children using a cognitive and social skills approach, aimed at the development of the 'optimistic child'. Parental involvement and family interventions are frequently educational when brought into play in these settings in multi-component programs. There is

also likely to be considerable emphasis on the teachers and school settings when more broadly based. There is a need for further development and testing of such programs, particularly those which enhance family functioning and provide cohesive and complementary links to the child's other powerful worlds of influence – for example, day care, preschool or school.

### **Family Disruption and Loss**

When family disruption occurs, through separation or divorce, or the death of a family member, families face a process of adaptation – both emotional and, with the balance shifts in family life, practical.

There are now a number of effective prevention programs which have been tested following the death of a parent. Black has led this field and reviewed the effectiveness of family and other interventions in these settings (Black and Young 1995). Both group and individual programs are likely to be helpful and enhance subsequent functioning for surviving parents and children. To these programs should be added the work of Murray (1996) with parents bereaved after infant death.

There are a number of intervention frameworks that may make a significant difference to outcomes in cases where divorce is inevitable. Bloom et al. (1985) have had the most extensive experience in this field and shown significant benefit at four-year follow-up for the parent, particularly for women, with lower levels of psychiatric morbidity and enhanced wellbeing, employment and life satisfaction. Such findings indicate substantial benefit for the group support and educational program, with individual support as needed. Programs aimed at meeting the needs of children as well as parents have been shown to be effective (Stolberg et al. 1982).

A range of programs have also looked at disadvantaged single-parent families, for instance in rural, poverty, or racial circumstances of marginalisation. These programs focus on support, enrichment, education and practical assistance. Many have demonstrated benefits in these settings, but have not been generalised to broader programs of implementation.

### **Families and Illness**

Family disruption caused by physical illness may well leave family members vulnerable to disorder, either the ill member, children or parents. Pless and Nolan (1989) have considered chronic childhood physical illness and implications for prevention, although effective programs have not yet been delineated.

Chronic psychiatric illness of a parent is likely to have significant implications, with the children of psychiatrically ill parents being identified as a high-risk group. Silverman (1989) has described the prevention perspective for this group, including for children of parents with affective disorder. Interventions require not only the prompt recognition and effective treatment of the disorder in the individual, but also the mobilising of effective family psycho-educational components

of treatment. These latter have been shown to have substantial positive effects for the outcome of both the affected person and the family.

However, it is likely a more focused approach should be provided for children in families where there is psychiatric illness of a parent. The generic risks related to the disruption of family functioning, parenting capacity and marital harmony that occurs with much psychiatric disorder mean that it is critically important that interventions address needs related to these risk elements, as well as the disorder itself.

Then there is also a need to take into account genetic and other vulnerabilities and their impact. Studies of children at risk of schizophrenia through family illness have described the multifactorial components of relevance and the need for systematic and long-term programs. However, none to date has been able to demonstrate effective prevention of schizophrenia, whether through family or other intervention. Psychiatric risk to the children has been found to be greater in the case of parental personality disorders associated with high levels of exposure to hostile behaviour. Boys with other risk factors were particularly vulnerable to the effects of parental disorder.

Substance abuse is another area where the complex mix of family dysfunction, parental illness and genetic contribution, may make prevention difficult. However, healthy functioning of other family members may protect children of alcoholic parents from adverse outcomes.

A protective approach is also applicable to other parental disorders and the role of grandparents and extended family may be particularly important in providing continuity of care. Preventive intervention may strengthen protective limits for families and local communities. Most programs to date have not specifically targeted families at risk, although both systematic treatment, support and self-help movements have dealt with them. Rather, there has been broader community and school based education. Outcomes of these are mixed.

With relation to psychiatric outcomes, there has also been some concentration on preventing suicide. However these programs have usually not focused on families, but on educational, community and health service systems. As Shaffer et al. (1989) point out, these programs have not as yet demonstrated effective prevention in terms of suicide outcomes. Brief interventions for young people who have made suicide attempts, and their families, are in the process of being evaluated.

### **Families in Poverty and Disadvantage**

It is clear that family functioning as well as the wellbeing of individual members will be substantially affected by social adversity. Schorr (1991) has described the impact on children and families of poverty and cycles of disadvantage, ranging from vulnerabilities to family disruption, poorer antenatal care, disadvantage due to birth complications, poorer physical health, lack of access to health and educational resources, greater levels of life stress, and fewer supports in

emergencies. It is clear that in such circumstances family mental health and wellbeing will inevitably suffer.

Add to this marginalisation and racism as affects, for example, Aboriginal and Torres Strait Islander families – families who have, as well, been subjected to traumatic separation, loss, premature mortality and disempowerment. The need for preventive approaches targeting the family unit has been demonstrated (Swan and Raphael 1995). Narrative family therapy, support for parenting, and programs of enrichment are all likely to be helpful, but as recent reports suggest, core societal changes may be critical. These must include not only employment, but changed social structures of reconciliation and renewal, with recognition of cultural difference, and responsibility and commitment from the whole community.

In circumstances of profound multi-level disadvantage, enrichment programs such as Head Start may have a significant place in preventing longer term negative outcomes, and some of this benefit may be due to strengthening family function, and promoting resilience. The longer term follow-up of these initiatives in the United States showed considerable benefit for the young people in late adolescent/early adult life, with better competence achievement, performance and wellbeing (Schweinhart and Weikart 1992).

Schorr (1991) suggested that preventive programs for disadvantaged populations most likely to be successful were those which emphasised relationships of trust and respect, focused on families, were deeply rooted in the community, and recognised those at greatest risk. Multiple risks will increase vulnerability and populations with accumulated vulnerabilities are likely to require intensive and multilevel intervention programs, which place particular emphasis on support of the parents, usually the mother.

In the longitudinal study of high risk children on the Hawaiian island of Kauai, it was apparent that there were significant individual differences in response to negative and positive care giving processes. Werner (1992) documented a range of clusters of protective factors in the lives of high risk children who functioned well in adult life. One of the clusters included: characteristics and care giving styles of the parents (for instance, affection and warmth) 'that reflected competence and fostered self-esteem in the child; mother's level of education; rules and structure in the households; for girls, the model of a mother who was gainfully employed' (p. 265).

### **Families and Violence**

Many of the above themes have touched upon the issue of conflict and discord in families. But among the most disruptive and pathologic influences in family life are abuse and violence. Domestic violence affecting women, and men to a lesser degree, has a profound negative impact on mental health and wellbeing.

The effects on children of witnessing violence have been identified as traumatic, impacting negatively on their mental health and wellbeing. The direct exposure of children to abuse and violence, be it physical,

emotional or sexual, has adverse effects in terms of the development of post-traumatic morbidity in childhood and subsequently (Herman 1992). Trauma occurring in other settings, such as random violence, disasters, war and political persecution, also has profound adverse effects for children and family, and requires effective short-term and longer-term preventive intervention.

Most abuse occurs in family settings, and is the product of distortions in parenting and family life. Transgenerational transmission of violence/abuse (Oliver 1993) has been shown to occur in one-third of instances, with a further third of those exposed to such abuse being vulnerable to parenting failures, and to potentially becoming abusive, in the face of stress.

These understandings provide a powerful impetus to the development of preventive programs. However, as elsewhere, it is essential to recognise that not all individuals will be at risk, and that factors promoting resilience and positive outcomes should be taken into account. For instance, in the context of child sexual abuse and adult pathology, it has been shown that, for women, negative childhood experiences may be mitigated by a positive relationship with one parent, rewarding experiences in adolescence (perhaps academic, or sporting), or in partner relationships.

While effective psychosocial interventions have been described for abused children, these have not as yet been demonstrated to be successful in preventing the child becoming an abuser, or breaking cycles, or preventing other morbidity. Where abuse is intrafamilial, family breakdown is likely, and this brings further difficulties for the child, even if essential for his or her protection. Broader abuse prevention programs focusing on the family are needed to lessen risk and to ensure a secure and appropriately nurturing environment for the child.

### Families and Ageing

There are a number of prevention opportunities during later developmental phases. As most older people with mental disorders live in the community, this can place significant burdens on carers, who are also ageing. Byrne (1995) notes that family carers of older people with mental disorders are themselves at increased risk of emotional distress and mental and physical disorders. Byrne suggests that preventive strategies could include respite care, support groups, telephone information and counselling, and practical assistance for carers.

With a growing aged population, bereavement and widowhood are significant mental and physical health risk factors. In a study of the elderly bereaved, Silverman (1988) suggested that those who were involved in the preventive program experienced fewer depressive symptoms and recovered more quickly than those who had not received such support.

It should also be remembered that loss of older family members can severely disrupt family networks and is especially significant in some cultures.

### Conclusion

There is as much that can be done effectively in the evidence-based prevention programs to prevent mental disorders in families as there is to treat them. The family is the core unit of all societies, even though its frameworks may vary with different cultural systems. Support for effective, affectionate, rewarding and realistic family systems is essential, but this should not be driven by stereotyped ideas of 'family values' that are not sensitive and responsive to changes in social structures and individual needs.

Families should be 'good enough' to be experienced as a source of joy and sustenance for members, even if at times they are challenging, demanding and difficult.

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